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Colin Pidgeon

Historic health and social care expenditure: comparative analysis

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The paper presents expenditure on health and social care in Northern Ireland in a comparative context. It is intended that it will serve to deepen the Committee for Health, Social Services and Public Safety's understanding of the level to which health and social care has historically been funded in Northern Ireland and to support its scrutiny of the Executive's Budget 2010 proposals.

Key Points

General

- There are two fundamental difficulties with attempting to provide expenditure data that is comparable between Northern Ireland and the other UK jurisdictions:
 - Expenditure is budgeted for in different ways. Because of these differences, it is not possible to accurately draw direct comparisons between expenditures on particular services – it would be extremely difficult, if not impossible, to ensure that like is being compared with like; and,
 - The health and social care budgets in Northern Ireland are integrated. It is not possible to establish exactly what is provided from a ‘health’ budget and what from a ‘social care’ budget, particularly in services (most obviously with care for the elderly or children) where the distinction between the two is almost by definition blurred.
- Differences in levels of expenditure do not necessarily indicate either greater or lesser outputs or better or worse health outcomes.
- The absence of comparable data undermines the concept of a national health service with national standards and funding. But demands for better data must be balanced with the cost and effort required to compile them

Health

- Compared with OECD countries, UK expenditure on health as a proportion of GDP is slightly lower than average (and the same as Ireland).
- On a per capita basis, UK health expenditure is slightly higher than the OECD average but lower than that of Ireland.
- In Northern Ireland expenditure on medical services has grown more in percentage terms over 4 years than in the other UK administrations. In per capita terms it is lower than Scotland and Wales and slightly higher than in England.
- Health spending as a proportion of total spending has remained three of four percentage points lower than in the other UK administrations.
- Per capita expenditure on health research looks high in comparison with the other UK administrations – but this may be due to the scoring of identifiable expenditure.
- Per capita expenditure on central and other health services also looks comparatively very high.

Social Care

- UK expenditure on care for the elderly is nearly double the EU average.
- The two figures for per capita spending on social care in Northern Ireland show either very high or very low levels. This may be due not to service funding but the way expenditure is scored.

Executive Summary

The research presented in this paper demonstrates the difficulties one comes up against when seeking to compare health and social care expenditure across the jurisdictions of the UK. Despite having what is ostensibly a national health service, data is not collected and presented in a way that makes comparative analysis easy, or particularly valuable.

What has been possible to discern is that whilst expenditure on 'medical services' in Northern Ireland has grown at a faster rate than in the other jurisdictions, the gap between the percentage of total budgeted expenditure that is devoted to health that existed in 2004/05 here and in the other jurisdictions has not closed. It is assumed that this is the reason that the Health Minister is able to make the claim that health in Northern Ireland is underfunded.¹

Professor John Appleby concluded in his review of 2005 that – on initial analysis – the HPSS sector in Northern Ireland seems to be reasonably well funded. But he also noted that this analysis however does not take account of potential need for higher expenditure here.²

One particular point that Committee members may be interested in pursuing further with the Minister is the level of expenditure per capita on 'central and other health services' (page 16). Taken at face value it would appear that despite reform, this expenditure is disproportionately high compared with the other UK jurisdictions.

The remainder of the data and analysis presented should provide members with a useful backdrop against which to consider the Minister's budget proposals when they are presented.

¹ See, for example, <http://www.belfasttelegraph.co.uk/news/health/can-michael-mcgimpsey-convince-his-colleagues-not-to-make-cuts-to-health-service-14865221.html> (accessed 2 December 2010)

² Appleby, J (2005) 'Independent Review of Health and Social Care Services in Northern Ireland' available online at: <http://www.dhsspsni.gov.uk/publications/2005/appleby/appleby-contents.pdf> (see page 34)

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1. Introduction

This paper was commissioned by the Committee for Health, Social Services and Public Safety to assist in scrutiny of budgetary and financial information provided by the Minister in relation to the Executive's Budget 2010 process.

The paper presents expenditure on health and social care in Northern Ireland in a comparative context. It is intended that it will serve to deepen the Committee's understanding of the level to which health and social care has historically been funded in Northern Ireland.

Because health and social care services are delivered on a different (integrated) model in Northern Ireland from the rest of the UK, it has proven difficult to find comparable and meaningful data. To aid reading of the data it is possible to present, the paper is divided into two parts: Part A presents expenditure data related to the provision of health services. Part B presents expenditure data related to the provision of social care.

Part A: Health Expenditure

A1. How does UK expenditure on health compare internationally?

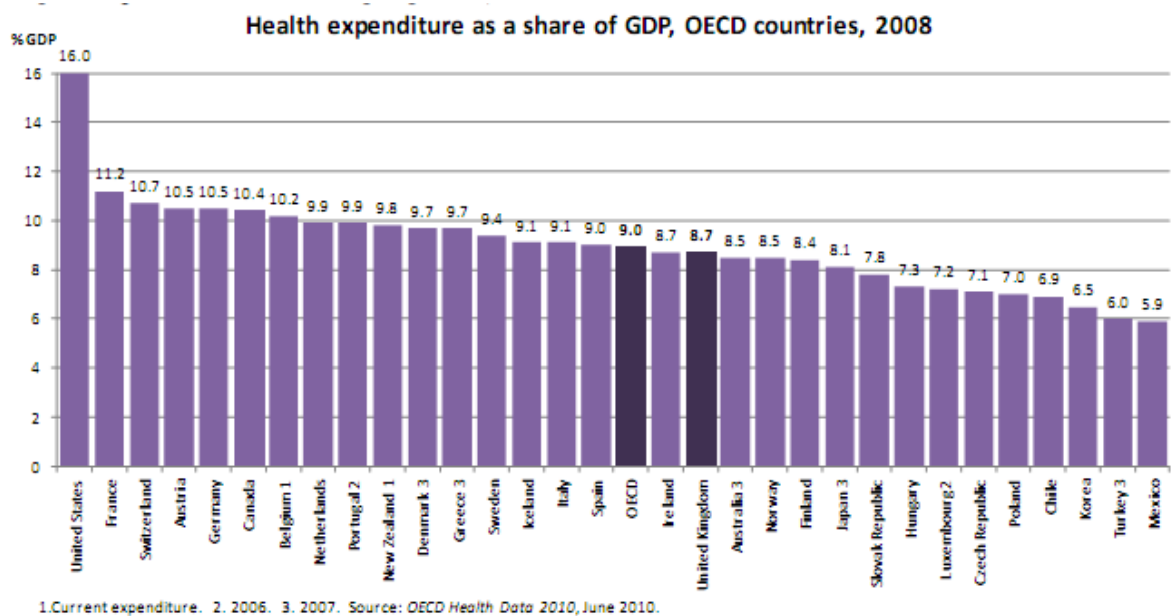
When looking at health expenditure in Northern Ireland, it is perhaps useful at the outset to consider where the UK as a whole fits into the international picture.

A1.1. Health expenditure as a percentage of Gross Domestic Product

Figure 1 below shows total health expenditure as a percentage of Gross Domestic Product (GDP) for the member countries of the Organisation for Economic Cooperation and Development (OECD) in 2008.

It is immediately apparent that - perhaps contrary to what one might expect with all the media and political attention on health spending – the UK as a whole spends slightly less on health than the OECD average. It is also noteworthy that the UK level of health expenditure expressed in these terms (8.7% of GDP) is the same as in the Republic of Ireland.

Figure 1 Health expenditure as a percentage of GDP in OECD countries.



Source: OECD Health Data 2010³

There are some other points that may be of interest to the Committee:

³OECD (2010) 'Health Data 2010: how does the UK compare?' available online at: <http://www.oecd.org/dataoecd/46/4/38980557.pdf> (accessed 8 November 2010)

- UK health expenditure as a percentage of GDP (8.7%) is just slightly over half that in the United States (16%).
- If one excludes the US, the range across the OECD is between 11.2% of GDP in France and 5.9% of GDP in Mexico. The mid-point of that range is 8.55%, which is very close to the UK figure of 8.7%.

Having said this, it is also relevant and quite important to re-emphasize that these figures relate to levels of expenditure. It is not necessarily the case that high levels of expenditure automatically convert to high levels of service provision. Professor John Appleby made this point succinctly in the *Independent Review of Health and Social care Services in Northern Ireland*:

...it is unwise to assume that higher spending necessarily means better health outcomes or greater activity. And similarly, it should not be assumed that all spending differences are unjustified; differences in the need for health and social care and the efficiency with which different systems convert financial inputs into health care outputs and health outcomes often provide legitimate reasons for differences in levels of spending.⁴

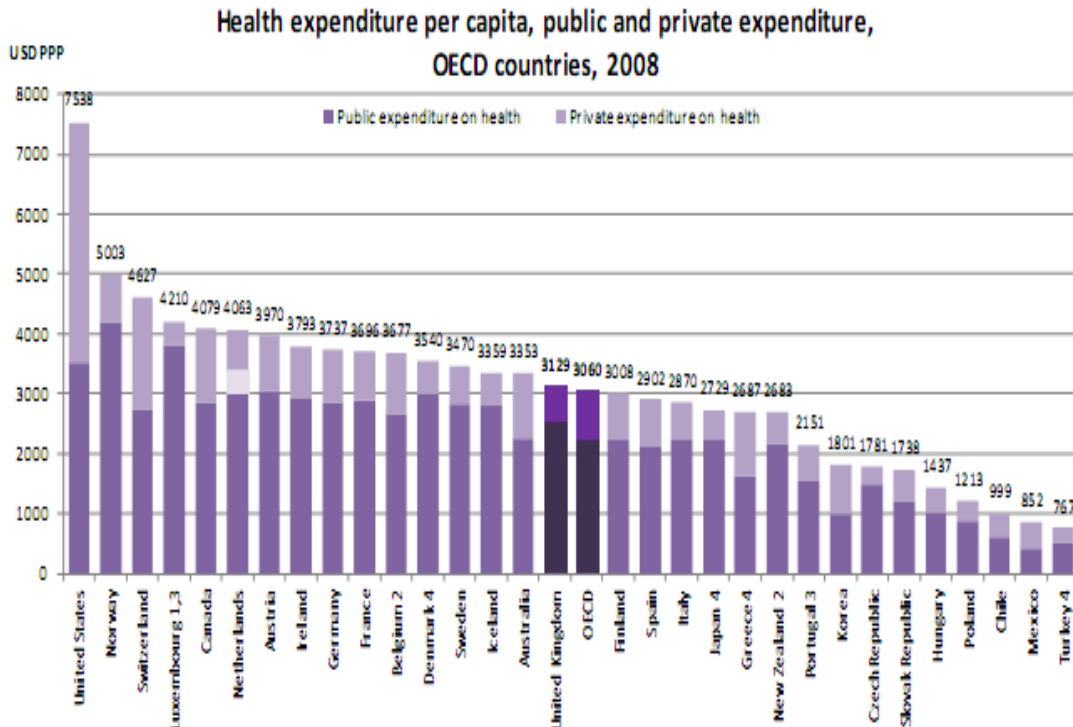
A1.2. Health expenditure per capita.

The OECD also produces a comparative table of expenditure per head of population. Figure 2 below presents figures in these per capita terms. It also shows the proportion of the total expenditure that is provided by the state from tax revenues (i.e. public expenditure) and by individuals from their own income (i.e. private expenditure).

Once again it is notable that health expenditure per capita in the UK at US\$ 3129 per head is very close to the OECD average of US\$ 3060 per head.

⁴ Appleby, J (2005) 'Independent Review of Health and Social care Services in Northern Ireland' available online at: http://www.dhsspsni.gov.uk/show_publications?txtid=13662 (accessed 17 November 2010) (see section 2.2, page 18)

Figure 2 Health expenditure per head in OECD countries.



1. Refers to insured population rather than resident population. 2. Current expenditure. 3. 2006. 4. 2007. Source: OECD Health Data 2010, June 2010.

Data are expressed in US dollars adjusted for purchasing power parities (PPPs), which provide a means of comparing spending between countries on a common base. PPPs are the rates of currency conversion that equalise the cost of a given 'basket' of goods and services in different countries.

Source: OECD Health Data 2010

Some other points that might be of interest to the Committee are:

- In the majority of OECD countries a larger proportion of total health expenditure is public rather than private. Exceptions to this are the United States, Korea and Mexico, where the public/private expenditure balance is more evenly split;
- Public health expenditure alone in the US is greater per head than total health expenditure per head in the UK;
- Public health expenditure per head is also greater than total UK health expenditure per head in Norway and Luxembourg;
- Public health expenditure per head in the UK is greater than total health expenditure per head in Portugal, the Czech and Slovak Republics, Hungary, Poland, Chile, Mexico and Turkey;
- Public health expenditure per head in the UK is quite similar to public health expenditure per head in Belgium and Switzerland;
- The proportion of total health expenditure per head in the UK from public sources (82.6%) is greater than the OECD average (72.8%); and
- UK per capita expenditure on health is notably lower than in the Republic of Ireland.

A1.3. Supply of health professionals, beds and diagnostic technologies: what does the UK get for its money?

In 2000, there were 2.0 doctors per 1,000 population in the UK. By 2008, this had increased to 2.6 doctors per 1,000 population. The OECD average in 2008 was 3.2 doctors per 1,000 population. Greece, Austria, Italy and Norway all record 4.0 doctors or more per 1,000 population.

In 2000, there were 8.7 nurses per 1,000 population in the UK. By 2008, this had increased to 9.5 nurses per 1,000 population. The OECD average was 9.0 nurses per 1000 population in 2008.

In 2008, there were 2.7 acute care hospital beds per 1000 population. The OECD average was 3.6 beds per 1000 population.

The number of MRI scanners in the UK in 2008 was 5.6 per 1,000,000 population. The OECD average was 12.6 per 1,000,000 population. The number of CT scanners in the UK in 2008 was 7.4 per 1,000,000 population. The OECD average was 23.8 per 1,000,000 population.⁵

While it is probably very simplistic to draw conclusions from these specific data, it is immediately noteworthy that whilst the UK spends close to the OECD average on health, it has fewer doctors and acute hospital beds than average. The UK also has fewer than half the MRI scanners and fewer than one third the CT scanners than the OECD average. The UK does, however, have slightly more nurses than the OECD average.

A request to the Department for comparable data has been submitted in the course of the preparation of this paper. At the time of writing a response had not been received.

⁵ OECD (2010) 'Health Data 2010: how does the UK compare?' available online at: <http://www.oecd.org/dataoecd/46/4/38980557.pdf> (accessed 8 November 2010) (see page 2)

Part A. How does health expenditure in Northern Ireland compare within the UK?

Whilst a comparison of spending on health at the UK level provides a useful backdrop, it is more relevant in the context of the Northern Ireland Executive's Budget 2010 process to see how spending in Northern Ireland compares with the other UK administrations.

A2. Total identifiable expenditure on all services.

Identifiable expenditure is a UK Treasury concept that seeks to show how much public money is spent in each of the UK regions and devolved administrations. Each UK government department and devolved administration provides annual statistical returns. The Treasury then produces statistical analyses of expenditure of the total of devolved administration and UK departmental spending that can be identified as benefiting the population of an individual region.

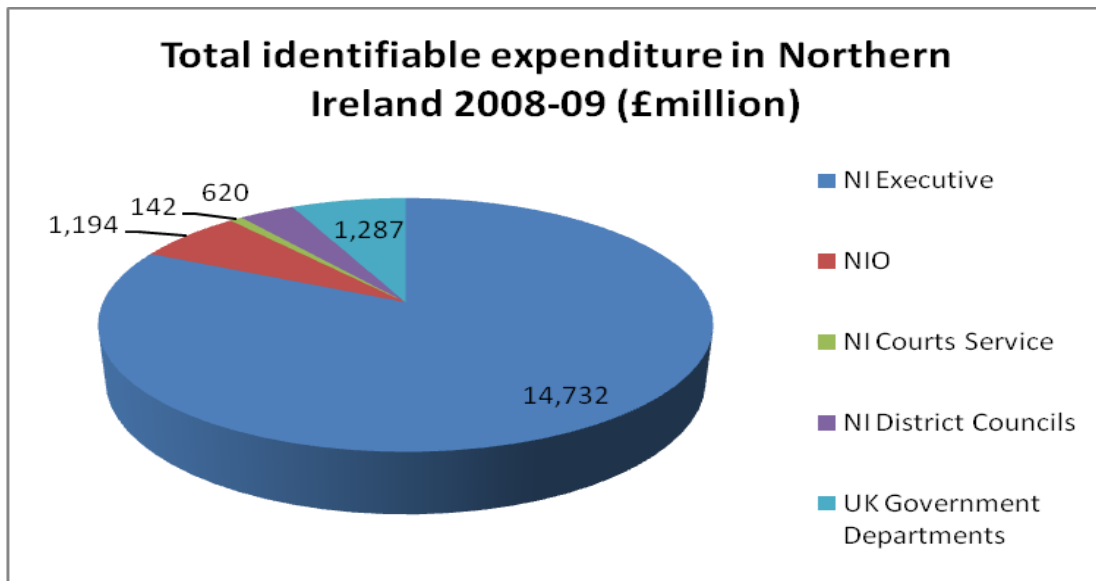
There are some difficulties with this approach:⁶

- Practical difficulties: hospitals, for example, are not used solely for the benefit of the residents in the region where the facility is located. Some very specialised services are not provided at regional levels. Definitional and border problems become more significant the smaller the geographical unit considered;
- Conceptual problems: for example, agricultural support is treated as benefitting the farmers who receive subsidies rather than the final consumers of subsidised food;
- Data collection issues: If spending is less than £20m annually on capital or current (and therefore in UK terms not significant) and/or relevant data for allocating it to regions is not available, departments may use proxies instead – such as straight population shares, for example. Also, identifiable expenditure only covers about 83% of Total Managed Expenditure (TME) because the remainder cannot be identified as benefiting individual regions – the most obvious example is defence spending but also spending on diplomatic functions, for instance. This remainder is considered to benefit the UK as a whole.

This means that in addition to expenditure directly by the Northern Ireland Executive, some of the expenditure of, for example, the Department of Work and Pensions is attributed to Northern Ireland. Figure 3 shows the breakdown of total identifiable expenditure in Northern Ireland, and where that money comes from.

⁶ For a detailed explanation of the limitations of this methodology, see http://www.hm-treasury.gov.uk/d/pesa2010_chapter9.pdf (see pages 40-43) (accessed 9 November 2010)

Figure 3 Total Identifiable Expenditure in Northern Ireland⁷



It should be noted that the data comes from 2008/09 and therefore expenditure on Policing and Justice is shown as coming through the Northern Ireland Office rather than the Northern Ireland Executive. When an equivalent table is available for years subsequent to the devolution to the Executive of those functions, the proportion will change accordingly.

A3. Comparison of expenditure across the UK

The Treasury data on health expenditure in the UK only provides a breakdown to a statistical level known as Classification of Functions of Government One (COFOG1). Expenditure on other areas such as education, housing and social protection is further broken down to COFOG2 which is more detailed.

In response to a query on the availability of COFOG2 data for health expenditure, the Treasury stated that:

...the Department of Health are unable to provide this detail as they do not budget expenditure by sub-function.

Providing this detail would not be cost effective and it is unlikely that DH will provide this detail in the near future.⁸

The data that are presented in the tables and charts that follow (below and in the Appendices), therefore, are in as much detail as it is possible to get. The COFOG1 breakdown is:

- Medical services;

⁷ Source HM Treasury

⁸ Source: personal communication with Treasury official.

- Health research; and
- Central and other services.

‘Health research’ is self-explanatory. Broadly speaking ‘central and other services’ is expenditure on administrative centres and the core departments and ‘medical services’ is everything else – from nurses’ pay and medicines to hospital buildings and bandages.⁹ What this means is that, essentially, the data is instructive only to a limited point.

The Treasury presents the expenditure data in two ways:

- in aggregate monetary terms; and
- in per capita terms.

A4. Aggregate expenditure on medical services.

Under the COFOG1 classification of total health expenditure, ‘medical services’ accounted for 98.4% of the UK total (£107,178m of £108,935m) in 2008/09.¹⁰ This figure reveals quite starkly the limitations of the data – a category of spending that is so overwhelmingly large compared to the other two categories means that all kinds of variations in expenditure for different purposes are, in effect, completely obscured from view.

Having said that, some observations can be made:

- expenditure on medical services rose in all four countries in each of the last five years and was planned to rise for 09/10; and,
- the growth from 04/05 to 08/09 (the most recent year for which outturn data is available) is shown below in Table 1. In percentage terms, expenditure on health grew more in Northern Ireland than in the other administrations.

Table 1 Growth in aggregate identifiable expenditure on medical services 04/05 to 08/09¹¹

£million	Identifiable expenditure 04/05	Identifiable expenditure 08/09	Increase	Percentage increase
England	66,559	88,660	22,101	33.2%
Scotland	7,596	9,871	2,275	29.9%
Wales	4,297	5,480	1,183	27.5%
Northern Ireland	2,339	3,167	828	35.4%

Please see figures A1.1 to A1.4 in Appendix 1 for the complete data for each administration.

⁹ Source: personal communication with Treasury official.

¹⁰ 2008-09 is the most recent year for which outturn data is available. The data for 09-10 is planned expenditure and so is subject to change as accounts are reconciled and audited.

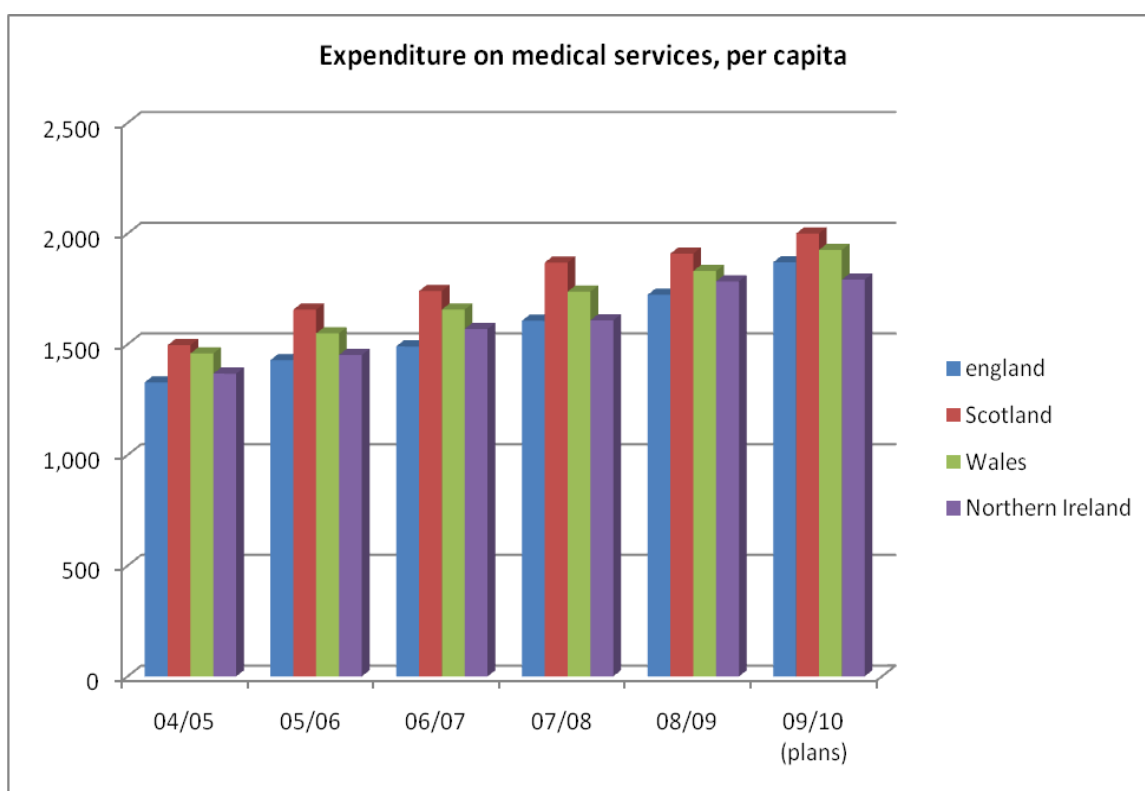
¹¹ Source: Assembly Research Service calculations based on HM Treasury data.

A5. Per capita expenditure on medical services.

The other way the Treasury presents the expenditure data is on a per capita basis. This allows for a relative comparison of areas with different population sizes. Given the large quantum of public money that is spent across the UK on health (and indeed the high proportion of total public expenditure), this is perhaps a more tangible and helpful way of comparing that expenditure across the administrations.

Figure 4 below shows total identifiable expenditure per head of population in each of the UK administrations. These figures relate purely to the total expenditure divided by the number of people in a geographical area. They do not in any way reflect the needs of local populations (and therefore the demands placed upon the health services) nor do they indicate anything in relation to value for money gained from that expenditure.

Figure 4: Identifiable expenditure on medical services, per capita, in each of the UK administrations 04/05 to 09/10¹²



The following observations can be made about these data:

- The pattern of per capita expenditure has not changed over the period. In other words, the 'shape' of the chart is relatively constant;
- Expenditure per head on medical services is highest in Scotland, followed by Wales, then Northern Ireland, then England; and,
- Only in 09/10 does per capita expenditure in England rise above that in Northern Ireland. Note that 09/10 is planned expenditure not outturn.

¹² Source HM Treasury

A6. Aggregate expenditure on health research

Under the COFOG1 classification of total health expenditure, 'health research' accounted for 0.45% of the UK total (£492m of £108,935m) in 2008/09.¹³ It is worth restating the point made in section 3.3 that the UK-level expenditure data does not readily allow comparisons to be made of other classifications. So, while it is possible to produce a detailed comparison of expenditure on health research, it should be remembered that it represents only a very small proportion of overall spend.

- Identifiable expenditure grew significantly in each of the administrations over the period, but there are large variations in the scale of that increase in percentage terms;
- Table 2 shows that by far the largest increase in health research expenditure between 04/05 and 08/09 was in Scotland; and,
- Health research expenditure in Northern Ireland grew by the smallest percentage.

Table 2: Growth in aggregate identifiable expenditure on health research 04/05 to 08/09¹⁴

£million	Identifiable expenditure 04/05	Identifiable expenditure 08/09	Increase	Percentage increase
England	169	295	126	74.6%
Scotland	29	106	77	265.5%
Wales	22	39	17	77.3%
Northern Ireland	39	52	13	33.3%

Please see figures A2.1 to A2.4 in Appendix 2 for the complete data for each administration.

A7. Per capita expenditure on health research

When considered on a per capita basis, identifiable expenditure on health research across the four administrations reveals a rather different picture. Figure 5 below shows total identifiable expenditure per head of population in each of the UK administrations. As noted in the section 3.4 these figures relate purely to the total expenditure divided by the number of people in a geographical area. They do not in any way reflect the needs of local populations (and therefore the demands placed upon the health services) nor do they indicate anything in relation to value for money gained from that expenditure.

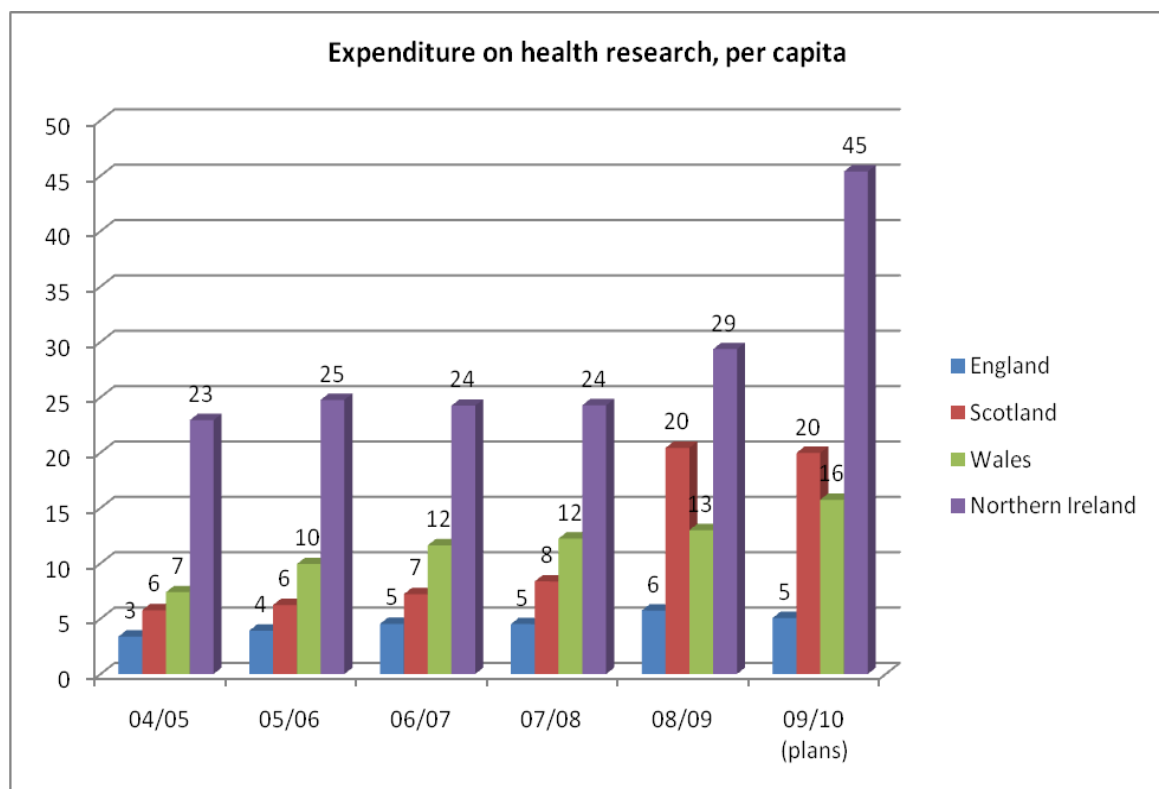
It is important that care is taken in interpreting these figures. There are a number of factors that could explain the noticeably higher level of per capita spending on health research in Northern Ireland:

¹³ 2008-09 is the most recent year for which outturn data is available. The data for 09-10 is planned expenditure and so is subject to change as accounts are reconciled and audited.

¹⁴ Source: Assembly Research Service calculations based on HM Treasury data.

- In section 3.1 above a number of possible difficulties with the approach of evaluating identifiable expenditure were noted. One such difficulty was ‘conceptual problems.’ In the same way that agricultural support is treated as benefitting the farmers who receive subsidies rather than the final consumers of subsidised food, it may be that the figures look so starkly different because expenditure on health research at Northern Ireland’s two universities is accounted for as benefitting the people of Northern Ireland. Queen’s University, Belfast, in particular conducts a considerable amount of health and other research and this might distort the data. Indeed it could be argued that the benefits of high-quality medical research are realised internationally when new breakthroughs are discovered; these data merely reflect spending, not the benefit from it.
- Medical research is expensive. The cost of a single large research project conducted in Northern Ireland would have a much larger impact in expenditure presented in per capita terms than if the same project were conducted in England – because England’s population is so many times greater than Northern Ireland’s.

Figure 5: Identifiable expenditure on health research, per capita, in each of the UK administrations 04/05 to 09/10¹⁵



There are some other observations that it is possible to make:

- The aggregate expenditure figures presented in Table 3 do not include 09/10 expenditure because the outturn data is not yet available. If the £45m in planned

¹⁵ Source HM Treasury

expenditure in Northern Ireland for that year was spent as planned, the percentage growth would be considerably higher (i.e. close to 96%) from 04/05 to 09/10.

- The pattern of per capita expenditure across the four administrations was similar from 04/05 to 07/08 (albeit it with annual increases in England, Scotland and Wales and relatively static expenditure in Northern Ireland) when a large increase in expenditure in Scotland alters the 'shape' of the figures.

A8. Aggregate expenditure on central and other health services

Under the COFOG1 classification of total health expenditure, 'central and other health services' accounted for 1.16% of the UK total (£1,263m of £108,935m) in 2008/09.¹⁶ Once again, it is worth restating the point made in section 3.3 that the UK-level expenditure data does not readily allow comparisons to be made of other classifications. So, while it is possible to produce a detailed comparison of expenditure on central and other health services, it should be remembered that it represents only a very small proportion of overall spend.

- Identifiable expenditure on central and other health services grew in each of the devolved administrations over the period –by considerably different percentage amounts – but declined in England.
- Identifiable expenditure on central and other health services grew by a noticeably lower proportion in Northern Ireland than in both Scotland and Wales.

Table 3: Growth in aggregate identifiable expenditure on central and other health services 04/05 to 08/09¹⁷

£million	Identifiable expenditure 04/05	Identifiable expenditure 08/09	Increase	Percentage increase
England	1,057	966	(91)	(8.6%)
Scotland	76	183	107	141%
Wales	14	34	20	142.9%
Northern Ireland	67	80	13	19.4%

Note: figures in (red) indicate negative growth (i.e. a reduction)

Please see figures A3.1 to A3.4 in Appendix 3 for the complete data for each administration.

A9. Per capita expenditure on central and other health services

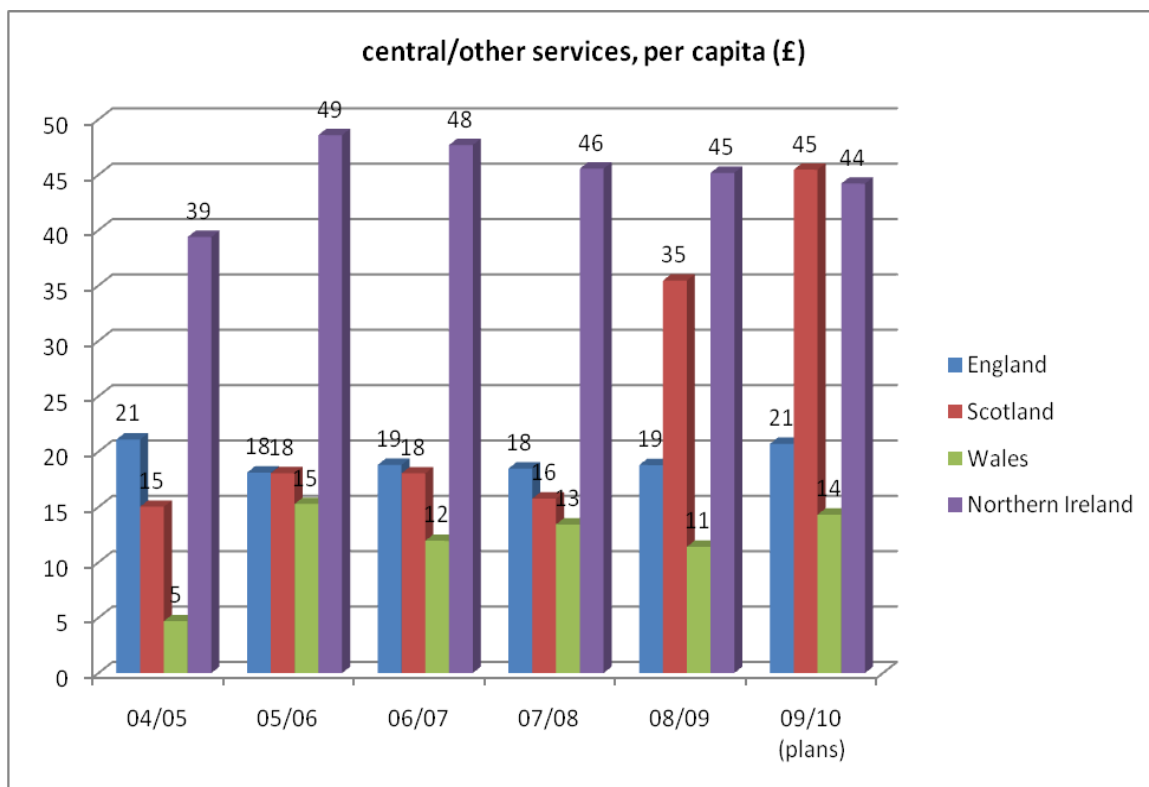
When considered on a per capita basis, identifiable expenditure on central and other health services across the four administrations reveals a rather different picture. Figure

¹⁶ 2008-09 is the most recent year for which outturn data is available. The data for 09-10 is planned expenditure and so is subject to change as accounts are reconciled and audited.

¹⁷ Source: Assembly Research Service calculations based on HM Treasury data.

6 below shows total identifiable expenditure per head of population in each of the UK administrations. As noted in the section 3.4 these figures relate purely to the total expenditure divided by the number of people in a geographical area. They do not in any way reflect the needs of local populations (and therefore the demands placed upon the health services) nor do they indicate anything in relation to value for money gained from that expenditure.

Figure 6 Identifiable expenditure on central and other health services, per capita, in each of the UK administrations 04/05 to 09/10¹⁸



It is possible to make some observations from these data:

- Identifiable expenditure per head on central and other health services is considerably higher in Northern Ireland than in the other administrations, although if the 09/10 outturn for Scotland is close to the planned figure it may overtake Northern Ireland spending;
- Identifiable expenditure per head on central and other health services has remained relatively constant in England;
- After a big increase between 04/05 and 05/06, identifiable expenditure per head on central and other health services in Northern Ireland has declined; and,
- There is a sudden and dramatic increase in identifiable expenditure per head on central and other health services in Scotland in 08/09, with a further large increase planned for 09/10. It is not clear why this increase is so pronounced, although it

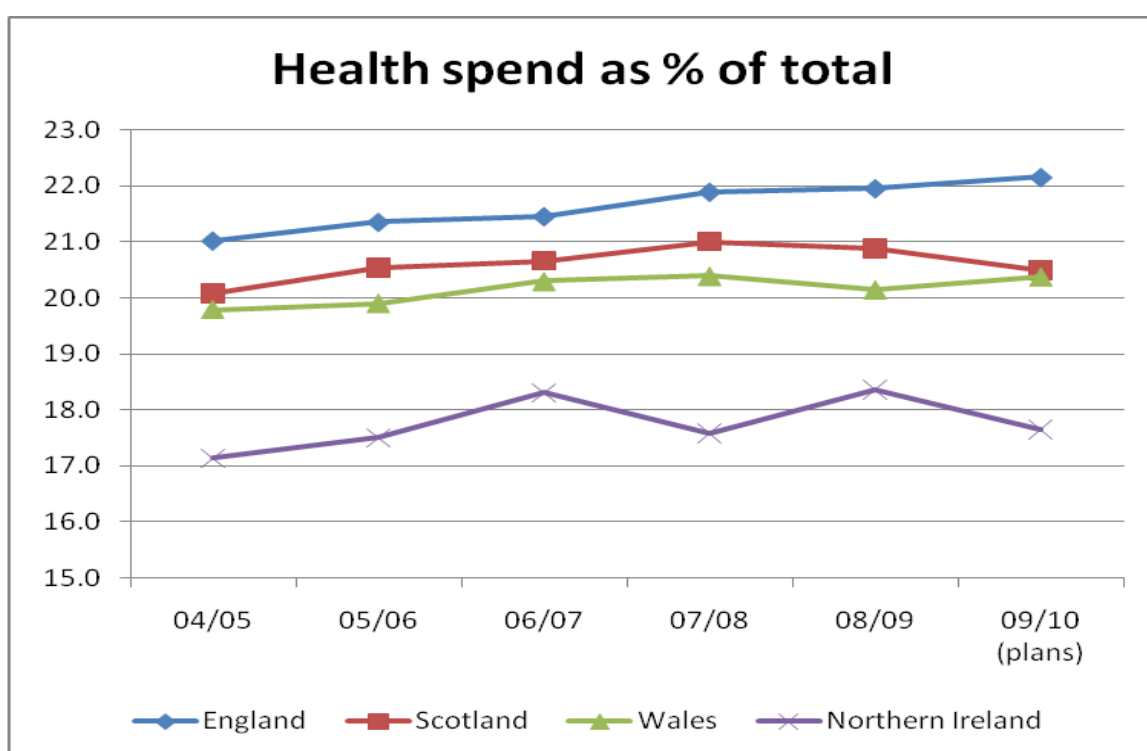
¹⁸ Source HM Treasury

may be due to healthcare reforms under the National Health Service Reform Act (Scotland) 2004.

A10. Expenditure on health as a proportion of total planned expenditure

A final comparison based on the Treasury data that is perhaps useful to the Committee is to consider health expenditure as a proportion of total expenditure. The data presented below are once again drawn from the Treasury tables on identifiable expenditure and so the notes above in sections A2 and A3 should be borne in mind when drawing conclusions from the figures.

Figure 7 Total identifiable expenditure on health as a proportion of total expenditure on all services¹⁹



This chart illustrates that - whilst expenditure on medical services has grown in Northern Ireland more than in the other UK administrations (see Table 1) – as a proportion of total spending on services, health expenditure in Northern Ireland has been consistently lower over the last half decade.

The *Independent Review of Health and Social care Services in Northern Ireland* (the Appleby Report) found that the need differential for health expenditure over and above the level in England was around 7% - although it was noted in the review that this figure was based upon modelling under various formulae that were highly sensitive to

¹⁹ Source Assembly Research calculations based on HM Treasury data

changes in the underlying assumptions.²⁰ In effect, this means that if relative need is taken into account Northern Ireland's expenditure on health should be a higher proportion of total expenditure.

The nature of the devolved funding arrangements mean that it is for the Northern Ireland Executive to decide how to distribute the block grant and the changes to that block that it receives through the Barnett Formula. The findings of the Appleby Report suggest that for health spending to be 7% higher than in England, this would require a 5% reduction in all other spending programmes.²¹

The Minister frequently makes reference to the relative underfunding of health and social care services in Northern Ireland. In the course of the research for this paper a request was submitted to the Department an explanation for the calculation behind this assertion. At the time of writing, no response had been received.

²⁰ Appleby, J (2005) 'Independent Review of Health and Social care Services in Northern Ireland' available online at: http://www.dhsspsni.gov.uk/show_publications?txtid=13662 (accessed 17 November 2010) (see Executive Summary, page 5)

²¹ Appleby, J (2005) 'Independent Review of Health and Social care Services in Northern Ireland' available online at: http://www.dhsspsni.gov.uk/show_publications?txtid=13662 (accessed 17 November 2010) (see section 2.3.5, page 53)

Part B

How does UK expenditure on social care compare internationally?

As when looking at health expenditure in Part A, it is helpful to briefly examine first how UK spending on social care compares with other jurisdictions.

B1.1 Spending on care for the elderly as a percentage of GDP

Much of the data available for the comparison of social expenditure does not strip out social services from benefits. This makes it difficult to see how much is spent on actual services rather than the payment of cash benefits to claimants with which to secure services.

One exception is that Eurostat does have data for the provision of care for the elderly. Figure 8 below shows expenditure on care for the elderly as a percentage of GDP across the European Union in 2007 and includes expenditure on:

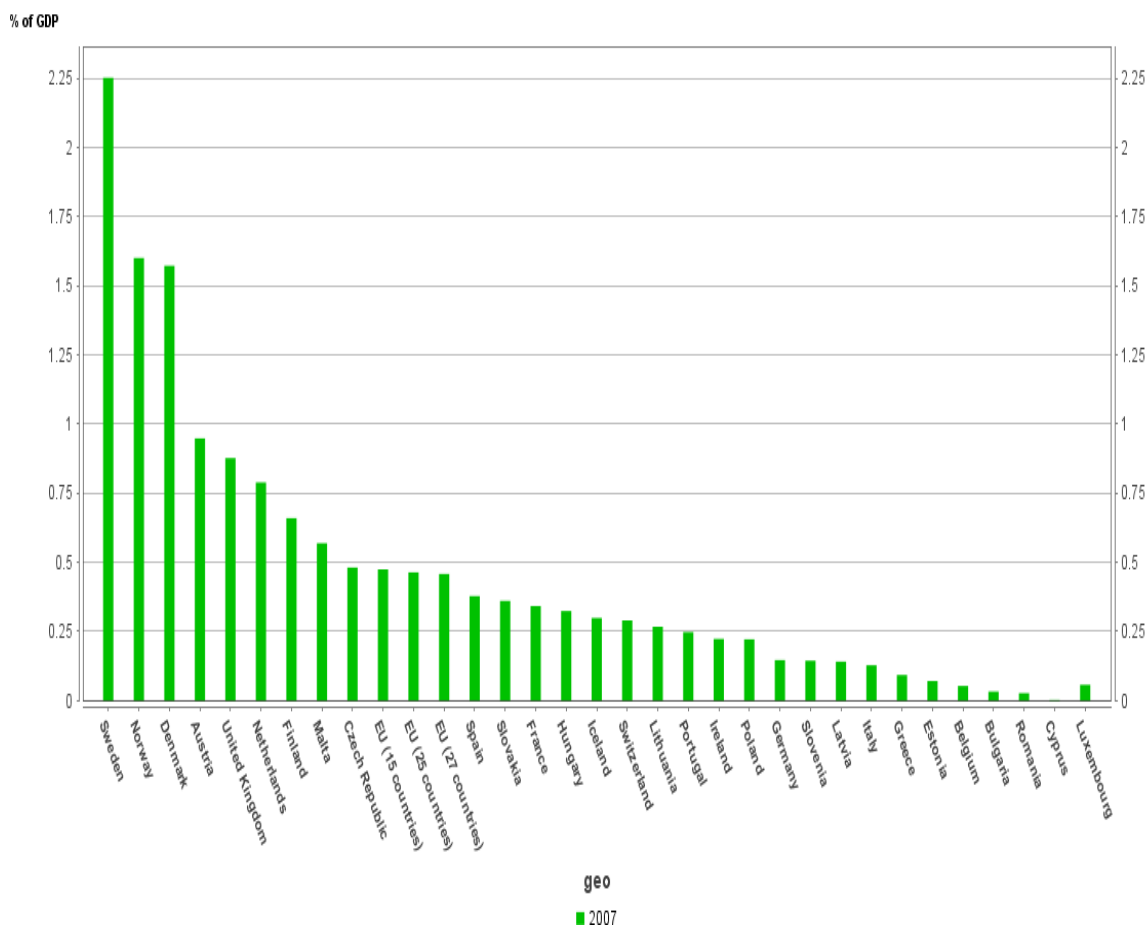
- care allowance;
- accommodation; and,
- assistance in carrying out daily tasks.

The data includes both public expenditure and private (where individuals collectively take out social insurance schemes but not, for example, individual life assurance policies).

Whilst this is only one aspect of social care, it is perhaps of interest to the Committee to see where the UK as a whole fits into this picture, and some observations may be drawn:

- There is a considerable range of expenditure on care for the elderly from 2.25% of GDP in Sweden to 0.003% of GDP in Cyprus;
- The average across the 27 EU countries is 0.458% of GDP;
- UK expenditure was 0.877% of GDP (just short of double the EU average); and,
- Ireland's expenditure was 0.223% of GDP (slightly more than one quarter of UK expenditure).

Figure 8 Expenditure on care for the elderly as a percentage of GDP across the EU, 2007



Source: Eurostat²²

Part B. How does social care expenditure in Northern Ireland compare within the UK?

Whilst a comparison of spending on social at the UK level provides a useful backdrop, it is more relevant in the context of the Northern Ireland Executive’s Budget 2010 process to see how spending in Northern Ireland compares with the other UK administrations.

B2. Aggregate expenditure on personal social services, sickness and disability

The Treasury’s data for total identifiable expenditure for personal social services related to sickness and disability are presented below in Table 4.

²²Available online at:

http://epp.eurostat.ec.europa.eu/NavTree_prod/AppLinkServices?pid=2318_54013006_2318_54012790_54012790&lang=en&appld=tgm&appUrl=http%3A%2F%2Fapp.eurostat.ec.europa.eu%2Ftgm%2Ftable.do%3Ftab%3Dtable%26init%3D1%26language%3Den%26code%3Dtsdde530%26plugin%3D1 (accessed 22 November 2010)

Table 4: Growth in aggregate identifiable expenditure on personal social services related to sickness and disability, 04/05 to 08/09²³

£million	Identifiable expenditure 04/05	Identifiable expenditure 08/09	Increase	Percentage increase
England	4,706	6,437	1731	36.8%
Scotland	540	747	207	38.3%
Wales	358	511	153	42.7%
Northern Ireland	682	823	141	20.7%

Some observations may be made from these data:

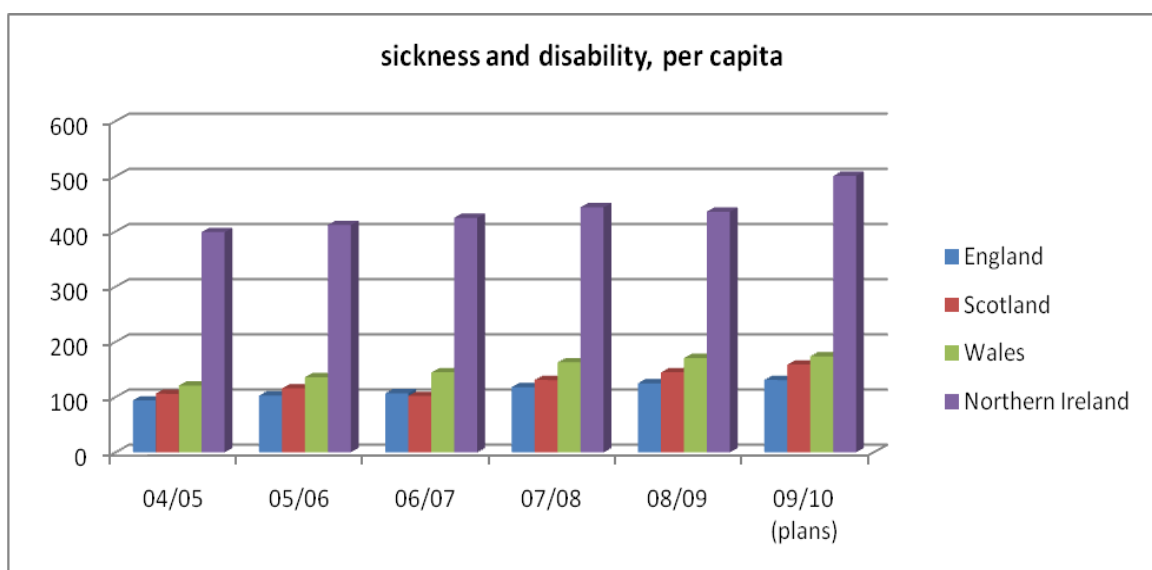
- Aggregate identifiable expenditure on this category of personal social services has grown in all administrations over the period;
- The largest growth in percentage terms was in Wales; and,
- The percentage growth in Wales was more than double the percentage growth in Northern Ireland.

Please see figures A4.1 to A4.4 in Appendix 4 for the complete data for each administration.

B3. Per capita expenditure on personal social services, sickness and disability

When the data for identifiable expenditure on personal social services are presented on a per capita basis, it is immediately apparent that expenditure per head in Northern Ireland is considerable higher than in the other administrations.

Figure 9: Identifiable expenditure on personal social services related to sickness and disability, per capita, in each of the UK administrations 04/05 to 09/10



²³ Source: Assembly Research Service calculations based on HM Treasury data.

B4. Aggregate expenditure on personal social services, family and children

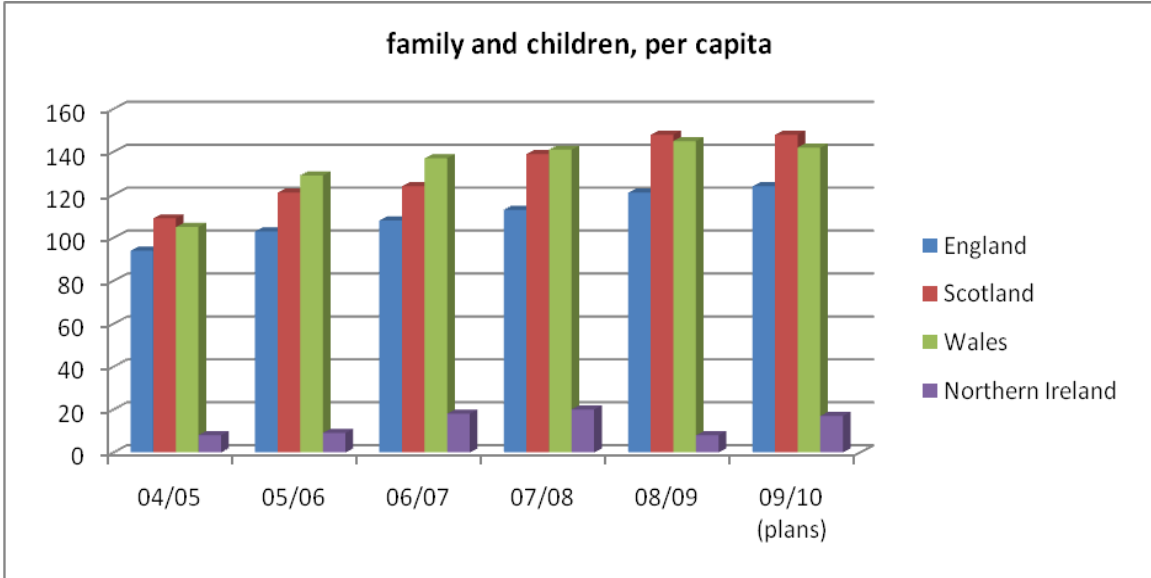
Table 5: Growth in aggregate identifiable expenditure on personal social services related to family and children, 04/05 to 08/09²⁴

£million	Identifiable expenditure 04/05	Identifiable expenditure 08/09	Increase	Percentage increase
England	4,703	6,234	1,531	32.6%
Scotland	555	766	211	38%
Wales	308	434	126	40.9%
Northern Ireland	14	14	0	0%

From these data it is possible to make some the observation that whilst expenditure on these services has grown significantly over the period, it has been flat in Northern Ireland. It should be noted however that the 0% increase masks annual variations that make it appear that spending in this area is volatile – see Figure A5.4 in Appendix 5.

B5. Per capita expenditure on personal social services, family and children

Figure 10: Identifiable expenditure on personal social services related to family and children, per capita, in each of the UK administrations 04/05 to 09/10



Taken at face value, it appears that spending in Northern Ireland on services related to family and children (in per capita terms) is remarkably low compared with the other UK jurisdictions. Care should be taken in making this assumption however, as Figure 9 presents something like a mirror image – with services related to sickness and disability accounting for a disproportionately high level of expenditure in Northern

²⁴ Source: Assembly Research Service calculations based on HM Treasury data.

Ireland relative to the other UK jurisdictions. It may be that these large variation are due to the way that the expenditure has been scored, rather than significant differences in funding for service.

During the course of the research for this paper, a request for clarification of these figures was submitted to the Department. At the time of writing, no response has been received.

Concluding remarks

The research presented in this paper highlights the absence of comparable (and meaningful) data on health expenditure across the UK.

In a recent study by the Nuffield Trust this point was well made:

...while, the UK statistics authority has a crucial role in monitoring the quality of statistics produced by each country, it does not appear to have the authority to require governments of the UK to produce comparable data on public services.²⁵

Indeed, the authors argue that:

If the Treasury cannot hold devolved governments to account for their performance through targets then it ought to be able to require them to supply comparative data on that performance to justify differences in spending per capita.²⁶

Whilst this notion may not rest easily with the principles of devolution within the UK, the point is made that UK taxpayers do have a right to ask questions:

the UK taxpayer may rightly question whether the generous funding of NHS Scotland has been directed not at meeting its greater needs, but at allowing its clinical staff to do less work than, for example, in the North East of England.²⁷

It should be noted that this question is based on an analysis of health staff 'crude productivity' and, therefore, there may be underlying explanations that do validate the level of expenditure. Nevertheless, the question posed is an interesting one in the context of devolution.

²⁵ Connolly, S, Bevan, G and Mays, N (2010) 'Funding and performance of healthcare systems in the four countries of the UK before and after devolution' available online at: <http://www.nuffieldtrust.org.uk/publications/detail.aspx?id=145&PRid=675> (accessed 23 November 2010) (see page 103)

²⁶ Connolly, S, Bevan, G and Mays, N (2010) 'Funding and performance of healthcare systems in the four countries of the UK before and after devolution' available online at: <http://www.nuffieldtrust.org.uk/publications/detail.aspx?id=145&PRid=675> (accessed 23 November 2010) (see page 103)

²⁷ Connolly, S, Bevan, G and Mays, N (2010) 'Funding and performance of healthcare systems in the four countries of the UK before and after devolution' available online at: <http://www.nuffieldtrust.org.uk/publications/detail.aspx?id=145&PRid=675> (accessed 23 November 2010) (see page 103)

The fact remains, however, that a comparison of expenditure data – to the limited extent that it is possible – is of limited value in understanding the underlying relative needs of populations and of the provision of care that is made for them.

Appendix 1: Total identifiable expenditure on medical services, by country.

Figure A1.1: total identifiable expenditure on medical services in England, 04/05 to 09/10.

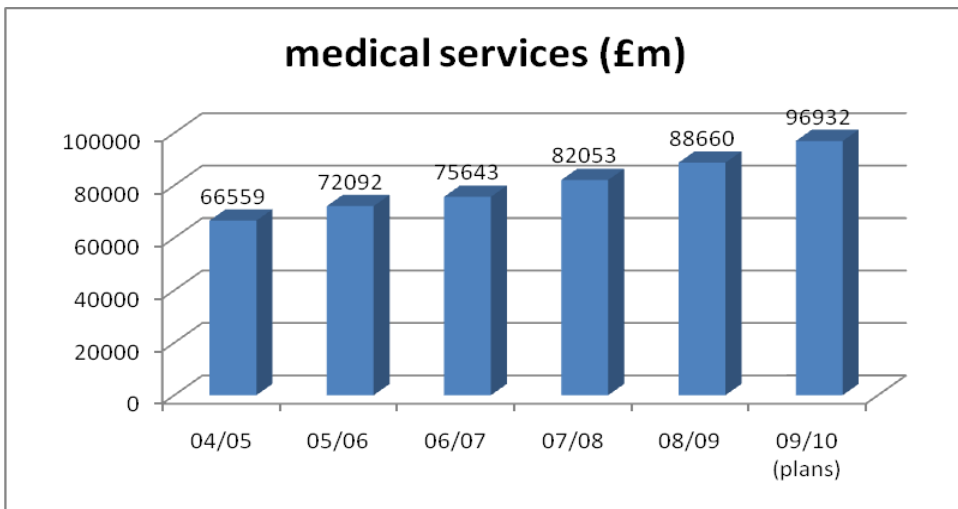


Figure A1.2: total identifiable expenditure on medical services in Scotland, 04/05 to 09/10

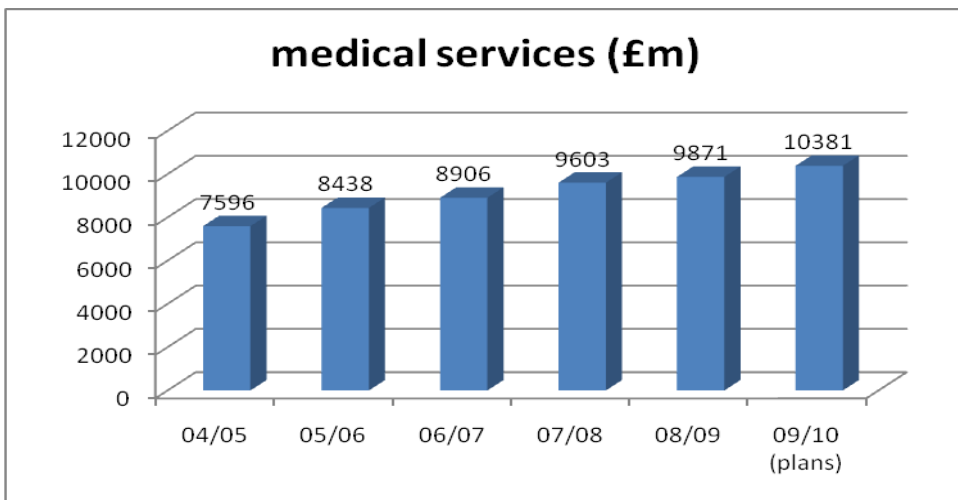


Figure A1.3: total identifiable expenditure on medical services in Wales, 04/05 to 09/10

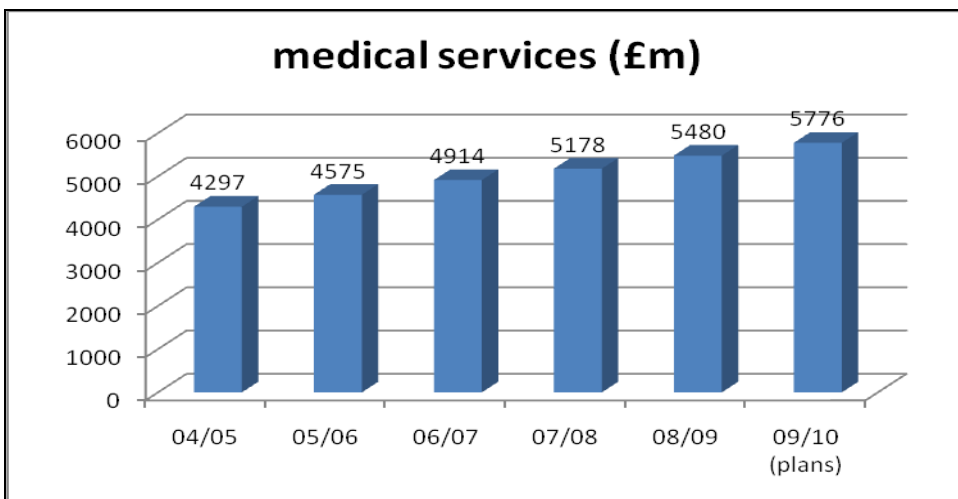
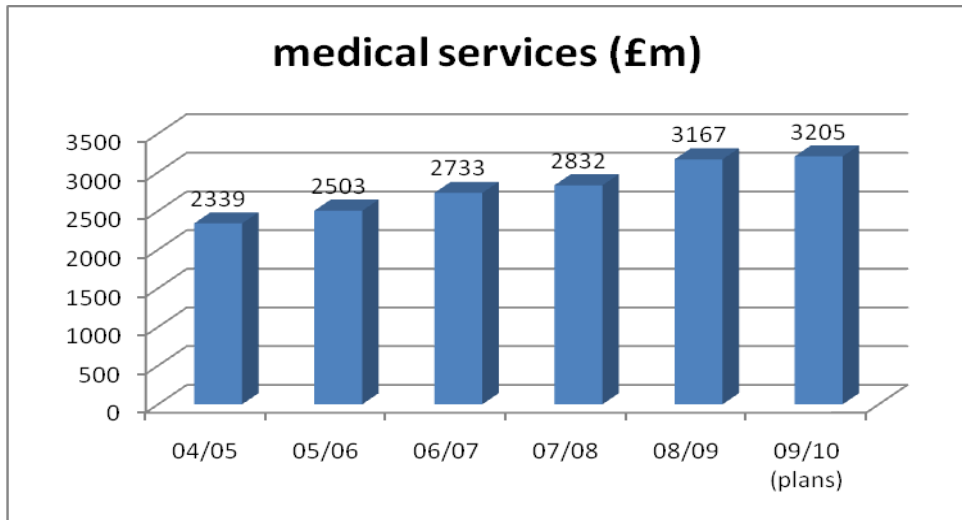


Figure A1.4: total identifiable expenditure on medical services in Northern Ireland, 04/05 to 09/10



Appendix 2: Total identifiable expenditure on health research, by country.

Figure A2.1: total identifiable expenditure on medical services in England, 04/05 to 09/10.

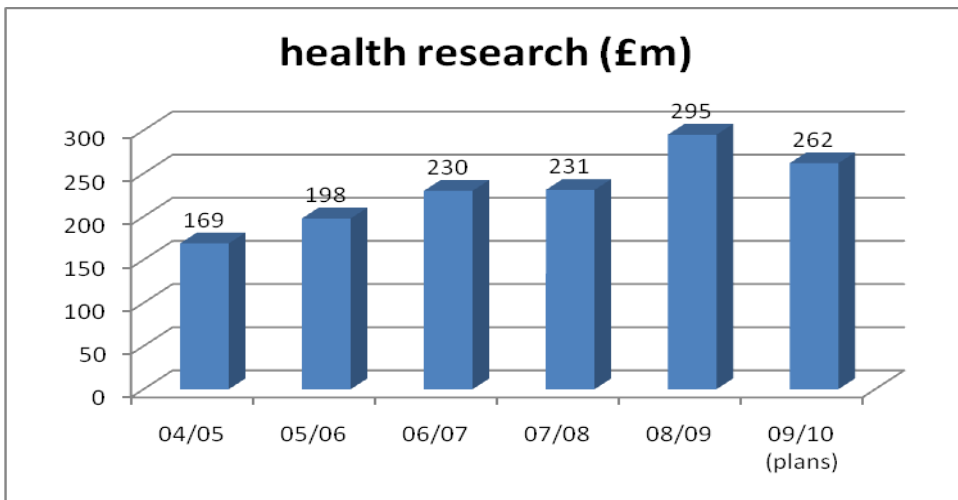


Figure A2.2: total identifiable expenditure on medical services in Scotland, 04/05 to 09/10.

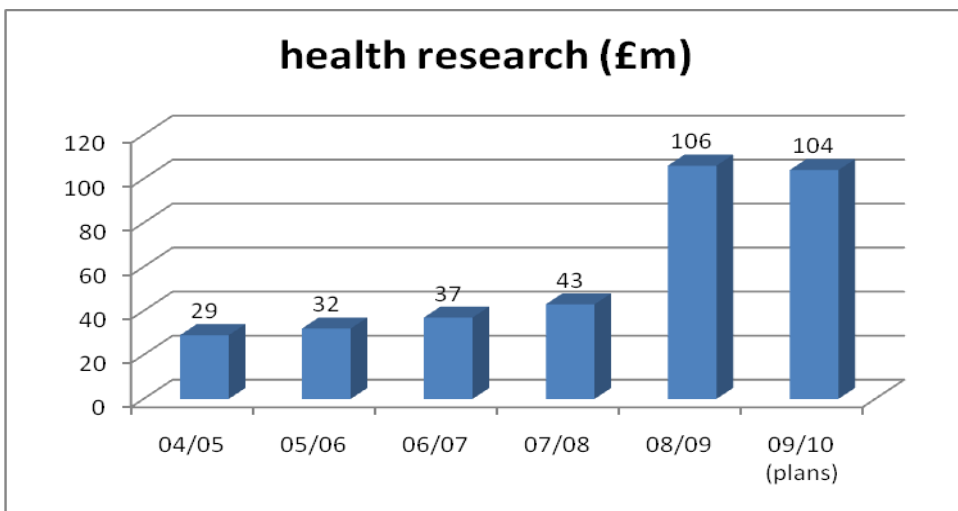


Figure A2.3: total identifiable expenditure on medical services in Wales, 04/05 to 09/10.

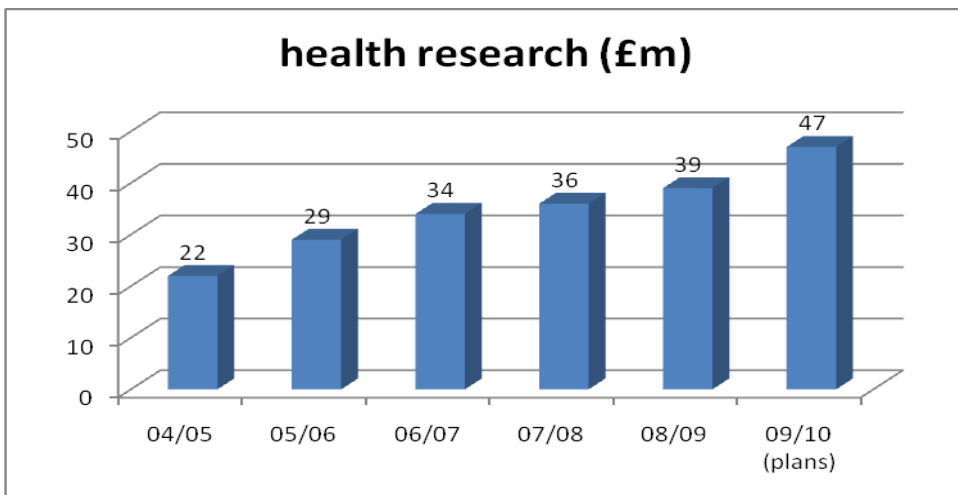
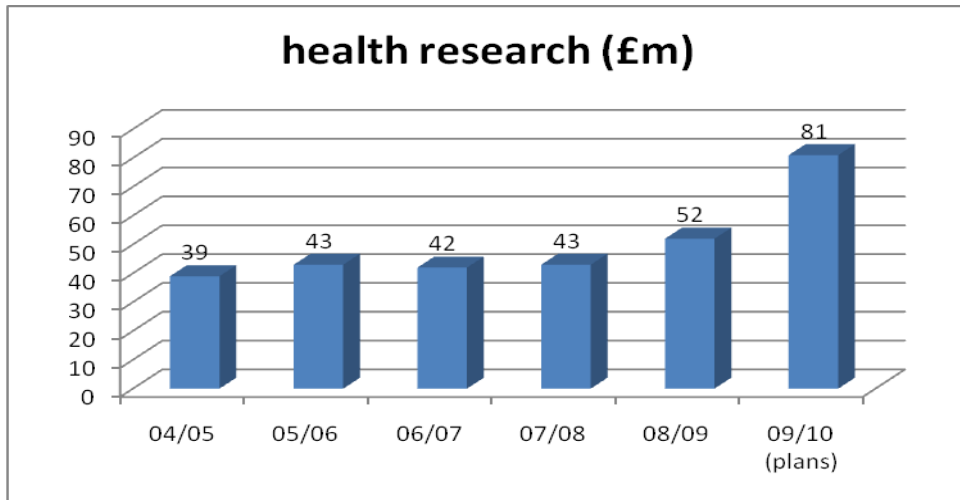


Figure A2.4: total identifiable expenditure on medical services in Northern Ireland, 04/05 to 09/10.



Appendix 3: Total identifiable expenditure on central and other health services, by country.

Figure A3.1: total identifiable expenditure on central and other health services in England, 04/05 to 09/10.

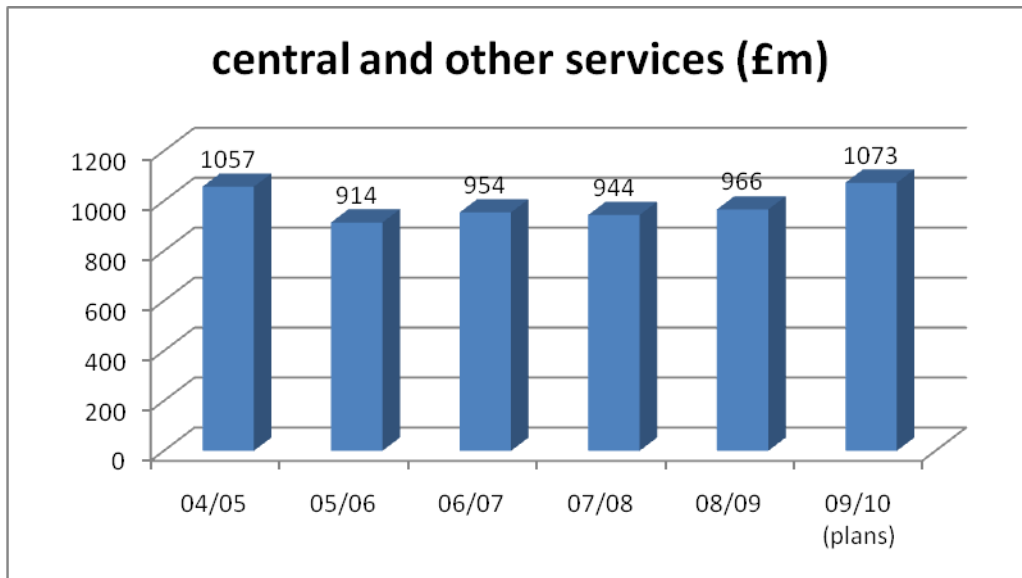


Figure A3.2: total identifiable expenditure on central and other health services in Scotland, 04/05 to 09/10.

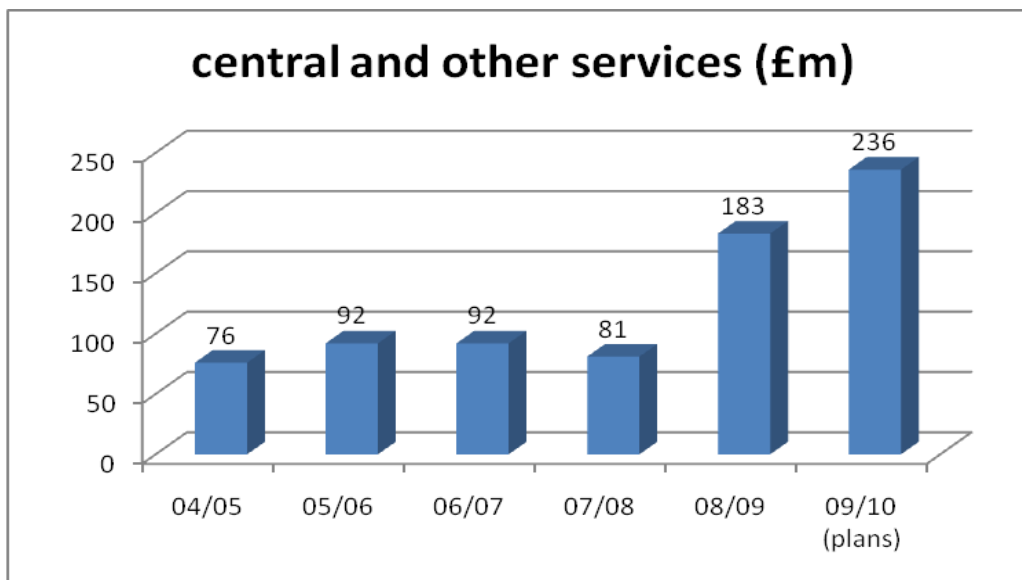


Figure A3.3: total identifiable expenditure on central and other health services in Wales, 04/05 to 09/10.

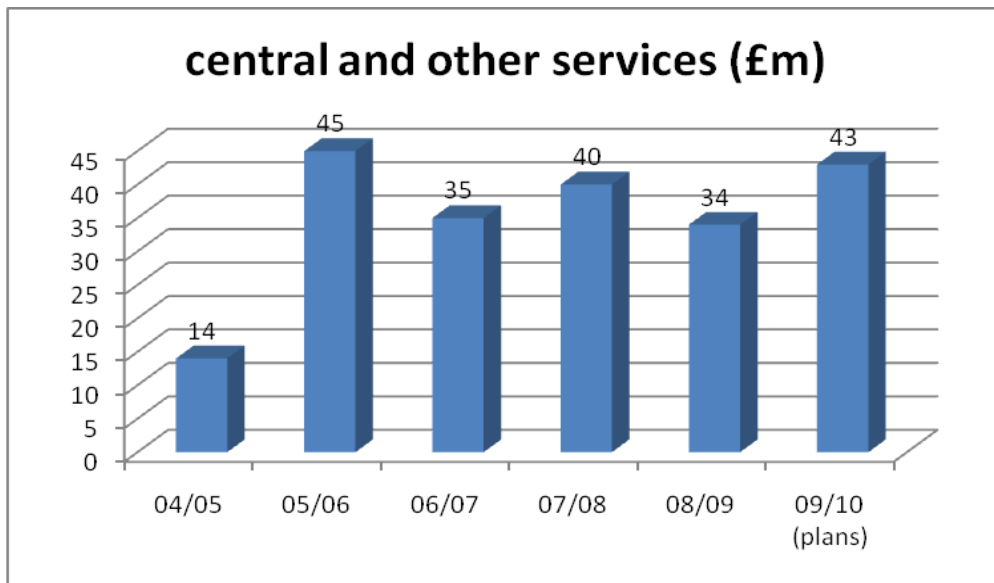
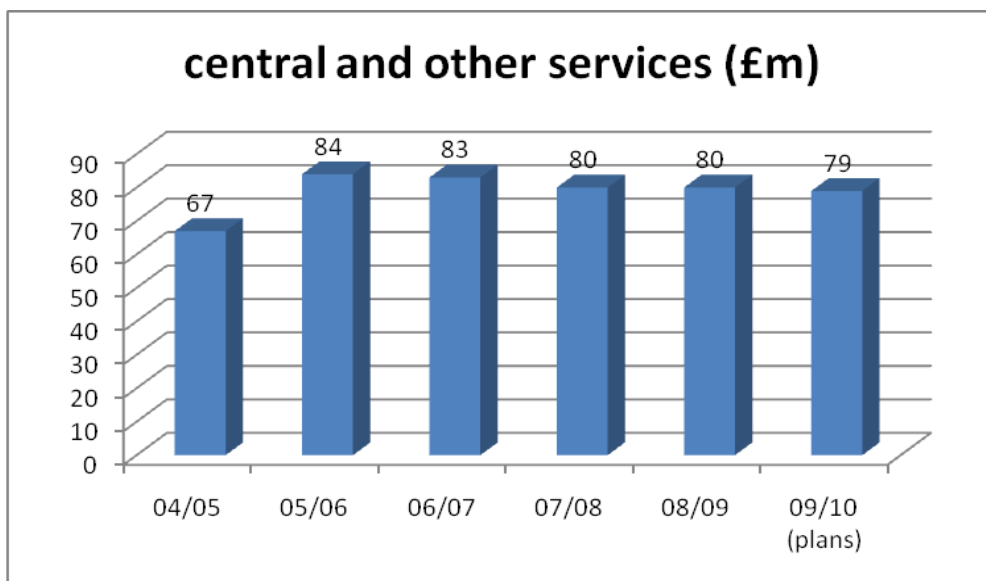


Figure A3.4: total identifiable expenditure on central and other health services in Northern Ireland, 04/05 to 09/10.



Appendix 4: Total identifiable expenditure on personal social services, related to sickness and disability, by country.

Figure A4.1: total identifiable expenditure on personal social services, related to sickness and disability in England, 04/05 to 09/10.

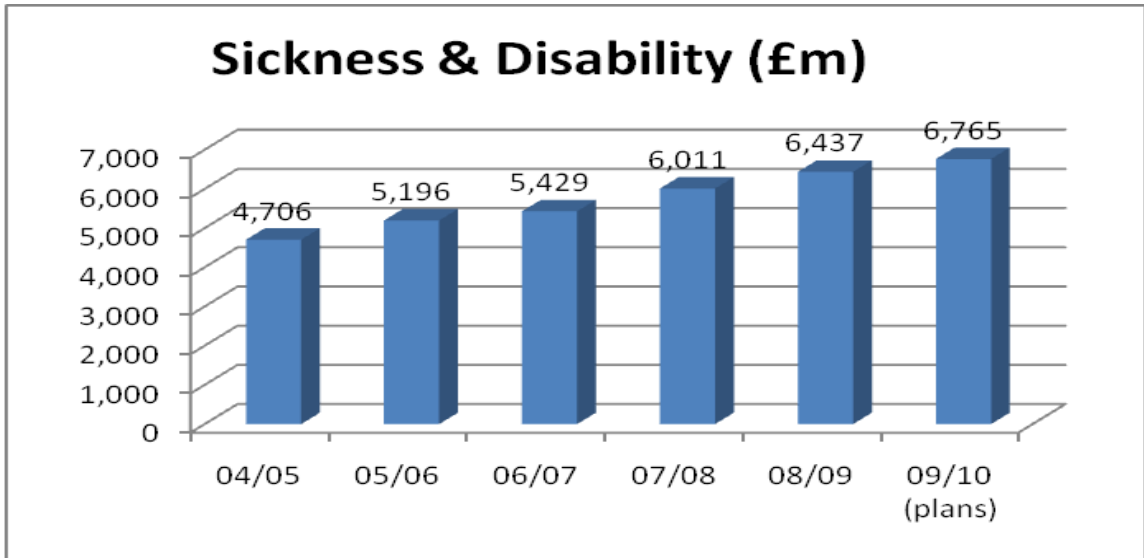


Figure A4.2: total identifiable expenditure on personal social services, related to sickness and disability in Scotland, 04/05 to 09/10.

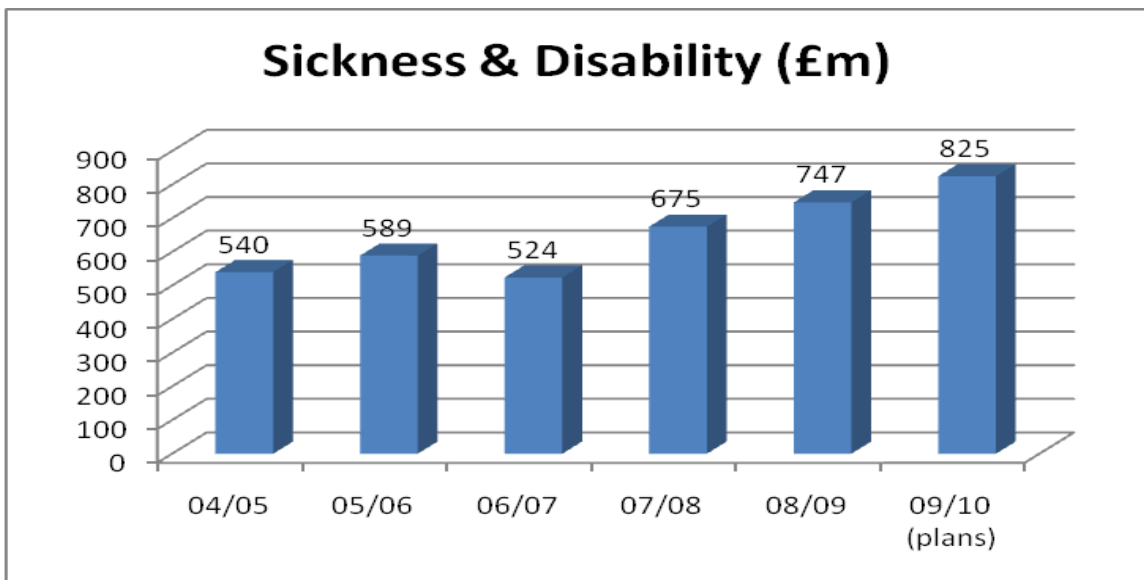


Figure A4.3: total identifiable expenditure on personal social services, related to sickness and disability in Wales, 04/05 to 09/10.

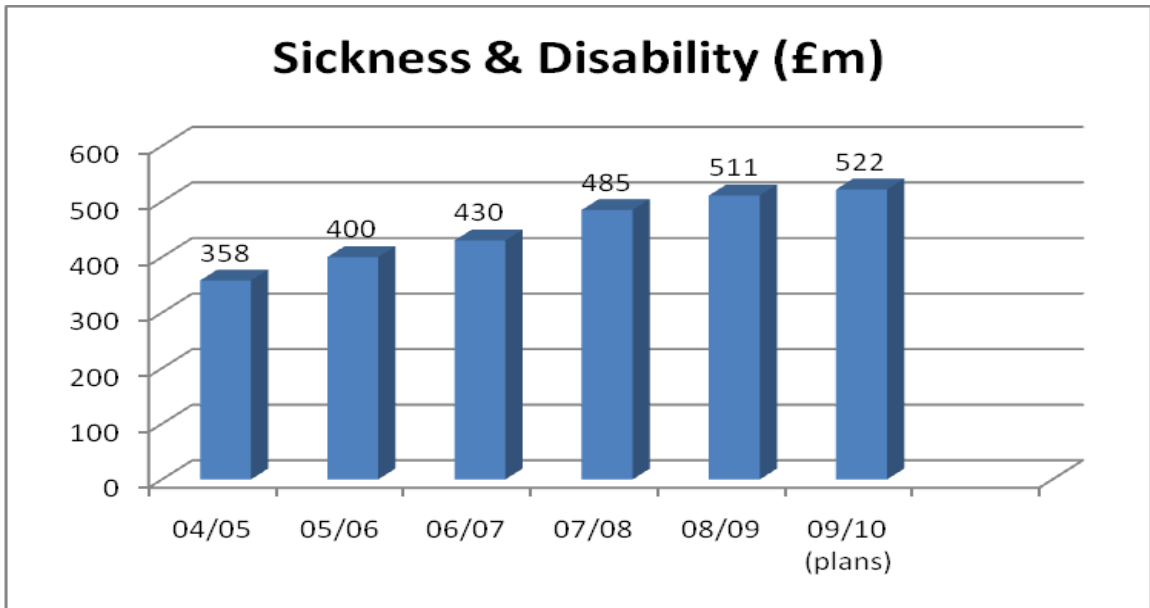
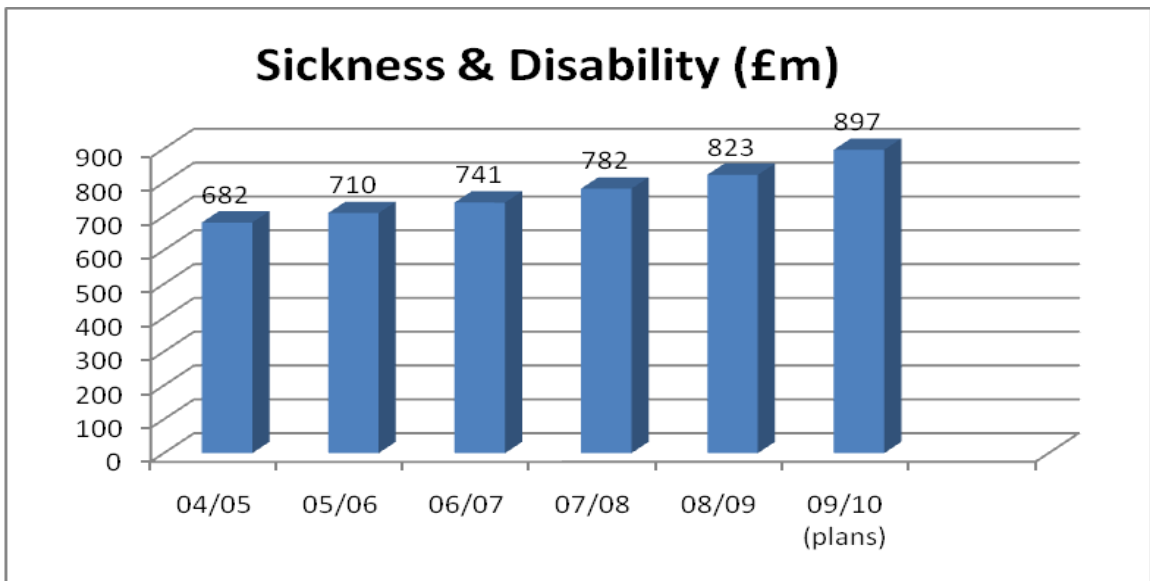


Figure A4.4: total identifiable expenditure on personal social services, related to sickness and disability in Northern Ireland, 04/05 to 09/10.



Appendix 5: Total identifiable expenditure on personal social services, related to family and children, by country.

Figure A5.1: total identifiable expenditure on personal social services, related to family and children in England, 04/05 to 09/10.

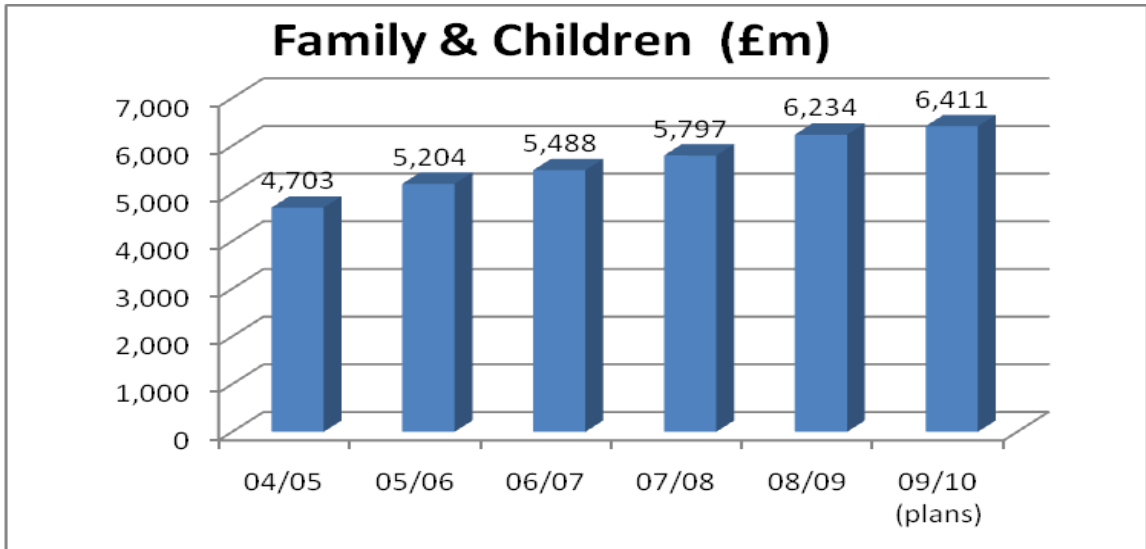


Figure A5.2: total identifiable expenditure on personal social services, related to family and children in Scotland, 04/05 to 09/10.

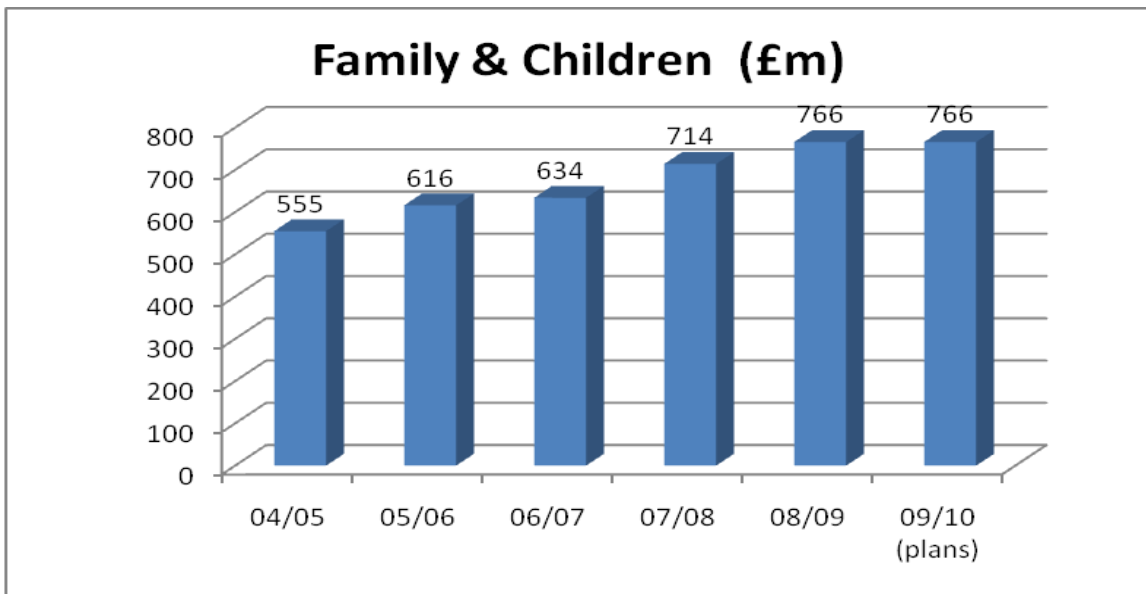


Figure A5.3: total identifiable expenditure on personal social services, related to family and children in Wales, 04/05 to 09/10.

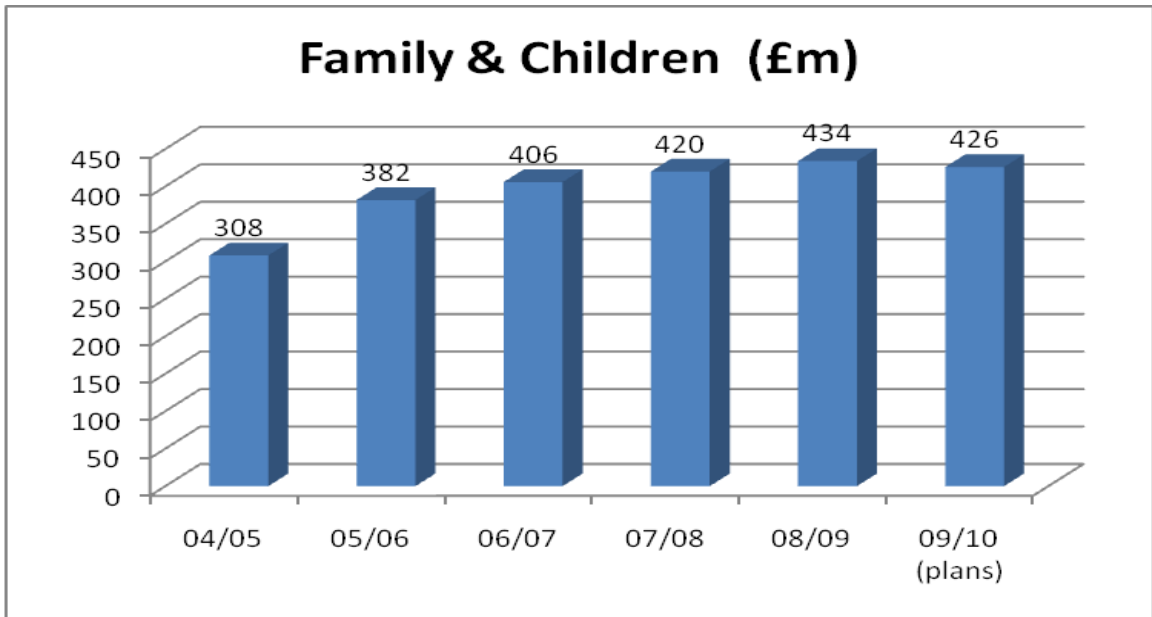


Figure A5.4: total identifiable expenditure on personal social services, related to family and children in Northern Ireland, 04/05 to 09/10.

